FOR BHF USE

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0010223

Facility Name: Odd Fellow-Rebekah Home

Address: 201 Lafayette Avenue, East (Number) Mattoon (City) 61938 (Zip Code)

County: Coles

Telephone Number: (217)235-5449 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: 1977

Type of Ownership:

xx	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
xx	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Ater **Telephone Number:** (309) 823-7135
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/10 to 6/30/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) David Standerfer
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Craig Ater, Exec VP & CFO
(Firm Name & Address) Heritage Operations Group, LLC
(Telephone) (309)823-7135 Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	162	Skilled (SNF)	162	59,130	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	162	TOTALS	162	59,130	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	28,663	10,158	5,831	44,652	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,663	10,158	5,831	44,652	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.51%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 1977

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified _____ and days of care provided 5,831

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	295,757	39,048		334,805		334,805		334,805			1
2	Food Purchase		336,375		336,375		336,375		336,375			2
3	Housekeeping	166,644	23,435		190,079		190,079		190,079			3
4	Laundry	56,113	12,890		69,003		69,003		69,003			4
5	Heat and Other Utilities			239,070	239,070		239,070		239,070			5
6	Maintenance	157,933	93,280	41,319	292,532		292,532		292,532			6
7	Other (specify):*											7
8	**TOTAL General Services**	676,447	505,028	280,389	1,461,864		1,461,864		1,461,864			8
	B. Health Care and Programs											
9	Medical Director			8,658	8,658		8,658		8,658			9
10	Nursing and Medical Records	2,218,167	174,021	10,464	2,402,652		2,402,652		2,402,652			10
10a	Therapy		292,431	677,167	969,598	(352,666)	616,932		616,932			10a
11	Activities	115,767	11,116		126,883		126,883		126,883			11
12	Social Services	84,823	85	5,335	90,243		90,243		90,243			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,418,757	477,653	701,624	3,598,034	(352,666)	3,245,368		3,245,368			16
	C. General Administration											
17	Administrative	93,016			93,016		93,016		93,016			17
18	Directors Fees											18
19	Professional Services			425,652	425,652		425,652	(10,306)	415,346			19
20	Dues, Fees, Subscriptions & Promotions			129,763	129,763	(88,695)	41,068	(21,114)	19,954			20
21	Clerical & General Office Expenses	254,233	28,491	27,466	310,190		310,190		310,190			21
22	Employee Benefits & Payroll Taxes			732,649	732,649		732,649		732,649			22
23	Inservice Training & Education			4,439	4,439		4,439	(2,440)	1,999			23
24	Travel and Seminar			16,478	16,478		16,478	(14,479)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			164,462	164,462		164,462		164,462			26
27	Other (specify):*			14,200	14,200		14,200	(14,000)	200			27
28	**TOTAL General Administration**	347,249	28,491	1,515,109	1,890,849	(88,695)	1,802,154	(62,339)	1,739,815			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,442,453	1,011,172	2,497,122	6,950,747	(441,361)	6,509,386	(62,339)	6,447,047			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Odd Fellow-Rebekah Home #0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			267,249	267,249		267,249		267,249			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,292	25,292		25,292	(9,853)	15,439			32
33	Real Estate Taxes			1,648	1,648		1,648	(1,648)				33
34	Rent-Facility & Grounds							(22,510)	(22,510)			34
35	Rent-Equipment & Vehicles			19,585	19,585		19,585		19,585			35
36	Other (specify):*											36
37	**TOTAL Ownership**			313,774	313,774		313,774	(34,011)	279,763			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					352,666	352,666		352,666			39
40	Barber and Beauty Shops		16		16		16		16			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					88,695	88,695		88,695			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		16		16	441,361	441,377		441,377			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,442,453	1,011,188	2,810,896	7,264,537		7,264,537	(96,350)	7,168,187			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space	(22,510)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(9,853)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions	(1,648)	33		15
16	Personal Expenses (Including Transportation)	(2,440)	23		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties				18
19	Entertainment	(14,479)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,306)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,000)	27		24
25	Fund Raising, Advertising and Promotional	(21,114)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (96,350)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (96,350)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Odd Fellow-Rebekah Home

ID# 0010223

Report Period Beginning: 07/01/10

Ending: 6/30/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(10,306)	19	22
23				23
24		(14,000)	27	24
25		(21,114)	20	25
26				26
27				27
28				28
29			33	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(45,420)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Odd Fellow-Rebekah Home **#** 0010223 **Report Period Beginning:** 07/01/10 **Ending:** 6/30/11

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,306)	0	0	0	0	0	0	0	0	0	0	(10,306)	19
20	Fees, Subscriptions & Promotions	(21,114)	0	0	0	0	0	0	0	0	0	0	(21,114)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	(2,440)	0	0	0	0	0	0	0	0	0	0	(2,440)	23
24	Travel and Seminar	(14,479)	0	0	0	0	0	0	0	0	0	0	(14,479)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(14,000)	0	0	0	0	0	0	0	0	0	0	(14,000)	27
28	**TOTAL General Administration**	(62,339)	0	0	0	0	0	0	0	0	0	0	(62,339)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(62,339)	0	0	0	0	0	0	0	0	0	0	(62,339)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Odd Fellow-Rebekah Home** **#** **0010223** **Report Period Beginning:** **07/01/10** **Ending:** **6/30/11**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,853)	0	0	0	0	0	0	0	0	0	0	(9,853)	32
33	Real Estate Taxes	(1,648)	0	0	0	0	0	0	0	0	0	0	(1,648)	33
34	Rent-Facility & Grounds	(22,510)	0	0	0	0	0	0	0	0	0	0	(22,510)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(34,011)	0	0	0	0	0	0	0	0	0	0	(34,011)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(96,350)	0	0	0	0	0	0	0	0	0	0	(96,350)	45

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	attached								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bonds--City of Mattoon		xx	Construction of 42 bed addition	$20,000.00	09/02/94	$	$ 403,750			$ 25,292	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$20,000.00		$	$ 403,750			$ 25,292	9
	B. Non-Facility Related*											
10	Interest Income										(9,853)	10
11	Allocated Corporate											11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (9,853)	14
15	TOTALS (line 9+line14)						$	$ 403,750			$ 15,439	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006		8
2007		9
2008		10
2009		11
2010		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Odd Fellow-Rebekah Home COUNTY Coles

FACILITY IDPH LICENSE NUMBER 0010223

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,305 B. General Construction Type: Exterior brick Frame wood Number of Stories

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 437,500	1
2					2
3	TOTALS			$ 437,500	3

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	162				$ 1,774,077	$		$	$	$	4
5					151,724						5
6					1,867,245						6
7											7
8											8
	Improvement Type**										
9	1979 Improvements			1979	28,527						9
10	1980 Improvements			1980	19,254						10
11	1981 Improvements			1981	45,037						11
12	1982 Improvements			1982	4,295						12
13	1983 Improvements			1983	106,089						13
14	1984 Improvements			1984	6,600						14
15	1985 Improvements			1985	34,689						15
16	1986 Improvements			1986	135,963						16
17	1987 Improvements			1987	1,732						17
18	1988 Improvements			1988	20,341						18
19	1989 Improvements			1989	322,810						19
20	1990 Improvements			1990	56,795						20
21	1991 Improvements			1991	25,089						21
22	1991 Improvements			1992	36,953						22
23	1993 Improvements			1993	16,174						23
24	1994 Improvements			1994	30,400						24
25	1995 Improvements			1995	48,815						25
26	1996 Improvements			1996	1,082,895						26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34						198,051		198,051			34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Roof	1997	$ 349,692	$		$	$	$	37
38	Architect Fees	1997	3,203						38
39	Wallpaper	1997	2,692						39
40	Water Hydrant	1997	5,430						40
41	Sinks, Cabinets	1997	496						41
42	Baseboards	1997	350						42
43	Woodframe Shed	1997	7,704						43
44									44
45	Water Heater	1998	14,664						45
46	Painting & Wallcovering	1998	4,567						46
47	Double drive gate & locks	1998	982						47
48									48
49	Carpet cleaning	1999	919						49
50	Exterior doors	1999	1,481						50
51	Water Heater	1999	7,660						51
52	Room renovations (wall coverings, tile, electrical)	1999	5,494						52
53	Decorating	1999	1,052						53
54	Window parts	1999	541						54
55									55
56	Baseboards, wallpaper	2000	1,120						56
57	Power panels	2000	2,722						57
58	Electrical outlets	2000	561						58
59									59
60									60
61	Booster Installation	2001	2,032						61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,228,866	$ 198,051		$ 198,051	$	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,228,866	$ 198,051		$ 198,051	$	$	1
2									2
3	Heat Exchanger	2002	4,724						3
4	LAN	2002	3,142						4
5	Water Heater	2002	7,397						5
6	Interior Renovations -- Entry Way	2002	7,493						6
7									7
8	Boiler	2003	1,941						8
9	Compressor	2003	6,361						9
10	Temperature control	2003	1,941						10
11	A/C Unit	2003	1,000						11
12	Smoke Detectors	2003	1,882						12
13	Lobby renovations: Wall paper, paint, floor coverings	2003	41,598						13
14	Kitchen Hood	2003	1,840						14
15	Firewall / Roof safty improvments	2003	32,502						15
16	Water Heater	2003	7,300						16
17									17
18	Lobby renovations: Wall paper, paint, floor coverings	2004	4,694						18
19	Water Heater	2004	2,516						19
20	Alzheimer Unit renovations: Wall paper, paint, floor coverings	2004	47,811						20
21	Alarm System	2004	2,863						21
22	Nurse Station	2004	29,661						22
23	Wallcoverings	2004	19,247						23
24	Wall Guards	2004	9,409						24
25	Corrodor Renovations	2004	15,153						25
26	Emergency Systems	2004	1,535						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,480,876	$ 198,051		$ 198,051	$	$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,480,876	$ 198,051		$ 198,051	$	$	1
2									2
3	Wire Access Doors	2005	3,568						3
4	Resident Room Remodel-- paint	2005	9,616						4
5	Compressor	2005	868						5
6	Grease Trap	2005	9,545						6
7	Garbage Disposal	2005	1,049						7
8	Fire Protection System	2005	3,332						8
9	2 Heat/ Cool Unit	2005	1,943						9
10	Heat Exchanger	2005	924						10
11	Security System	2005	1,095						11
12	Dinning room Remodel--Paint/Wallpaper/carpet	2005	7,114						12
13	Insurance Proceeds--roof repair	2005	(16,568)						13
14									14
15	Dinning room Remodel--Paint/Wallpaper/carpet	2006	20,984						15
16	Roof/Fence Replacement	2006	21,748						16
17	Sidewalk	2006	1,637						17
18	Remodel Therapeutic Rehab Unit	2006	28,486						18
19									19
20	Remodel Therapeutic Rehab Unit (paint, carpet, fixtures)	2007	4,343						20
21	Rooftop compressor	2007	1,362						21
22	Wiring for IT	2007	4,200						22
23	Heat Exchanger	2007	988						23
24	West Wing Remodel--Paint/Wallpaper/carpet	2007	5,534						24
25	Water Heater	2007	12,335						25
26	Roof repair	2007	1,157						26
27	Compressor	2007	1,237						27
28	HVAC unit	2007	967						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,608,340	$ 198,051		$ 198,051	$	$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,608,340	$ 198,051		$ 198,051	$	$	1
2									2
3	Compressor	2008	1,446						3
4	Bather	2008	1,673						4
5	Heat Exchanger	2008	5,760						5
6	Light Fixture	2008	812						6
7	Doors	2008	6,986						7
8	Boiler	2008	1,114						8
9	Wander Guard	2008	2,968						9
10	Floor Tile	2008	2,283						10
11	PTAC Unit	2008	971						11
12	Roof -- Harmony Corridor	2008	7,630						12
13	Vent Sleeves	2008	1,275						13
14	Blinds	2008	1,143						14
15	Fire System	2008	3,424						15
16	Compressor	2008	1,295						16
17	Ridge Vent	2008	4,330						17
18	Employee Entrance Door	2008	1,343						18
19									19
20	Hallway Floor Replacement	2009	104,987						20
21	Heat Exchanger	2009	5,714						21
22									22
23	New Roof	2010	125,051						23
24	Water Meter valve	2010	3,113						24
25	Awning Front Entrance	2010	3,630						25
26	Water Heater	2010	11,977						26
27	Paint, Floor Tiles (Rehab to Home Rooms)	2010	3,158						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,910,423	$ 198,051		$ 198,051	$	$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,910,423	$ 198,051		$ 198,051	$	$	1
2									2
3	Compressor	2011	7,961						3
4	Dryer Enclosure	2011	11,862						4
5	Water Heater	2011	12,800						5
6	Concrete Patio Floor	2011	2,675						6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,945,721	$ 198,051		$ 198,051	$	$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,610,035	$ 69,198	$ 69,198	$		$	71
72	Current Year Purchases	145,069						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,755,104	$ 69,198	$ 69,198	$		$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,138,325	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 267,249	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 267,249	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 19,585 Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 237,916	$		$ 237,916	1
2	Licensed Speech and Language Development Therapist		hrs			113,394			113,394	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			264,472	1,150		265,622	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				291,281		291,281	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					61,385			61,385	13
14	TOTAL			$		$ 677,167	$ 292,431		$ 969,598	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Odd Fellow-Rebekah Home **#** 0010223 **Report Period Beginning:** 07/01/10 **Ending:** 6/30/11

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/11 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,021,289	$	1
2	Cash-Patient Deposits	16,124		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	302,022		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	62,098		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	2,387,283		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,788,816	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	7,585,224		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,625,121		16
17	Accumulated Depreciation (book methods)	(6,260,036)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,950,309	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,739,125	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 258,132	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,124		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	386,052		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,718		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 675,026	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	403,750		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 403,750	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,078,776	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,660,349	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,739,125	$	48

***(See instructions.)**

Facility Name & ID Number Odd Fellow-Rebekah Home **#** 0010223 **Report Period Beginning:** 07/01/10 **Ending:** 6/30/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,301,273	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,301,273	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	359,076	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 359,076	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,660,349	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,590,876	1
2	Discounts and Allowances for all Levels	(2,484,293)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,106,583	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,982,977	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,982,977	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	74	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	22,510	16
17	Sale of Drugs	493,735	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	20,429	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 536,748	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,853	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,853	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		(12,548)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (12,548)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,623,613	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,461,864	31
32	Health Care	3,598,034	32
33	General Administration	1,890,849	33
	B. Capital Expense		
34	Ownership	313,774	34
	C. Ancillary Expense		
35	Special Cost Centers	16	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,264,537	40
41	**Income before Income Taxes (line 30 minus line 40)****	359,076	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 359,076	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,952	2,080	$ 52,471	$ 25.23	1
2	Assistant Director of Nursing	1,952	2,080	49,347	23.72	2
3	Registered Nurses	7,165	7,538	232,640	30.86	3
4	Licensed Practical Nurses	23,856	25,812	637,699	24.71	4
5	CNAs & Orderlies	87,132	93,914	1,233,084	13.13	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,200	1,200	12,926	10.77	8
9	Activity Director					9
10	Activity Assistants	8,496	9,371	115,767	12.35	10
11	Social Service Workers	5,002	5,633	84,823	15.06	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,724	26,619	295,757	11.11	15
16	Dishwashers					16
17	Maintenance Workers	9,532	10,756	157,933	14.68	17
18	Housekeepers	14,953	16,543	166,644	10.07	18
19	Laundry	5,804	6,230	56,113	9.01	19
20	Administrator	1,900	2,080	93,016	44.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,353	12,529	254,233	20.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	204,021	222,385	$ 3,442,453 *	$ 15.48	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		8,658		36
37	Medical Records Consultant		1,644		37
38	Nurse Consultant				38
39	Pharmacist Consultant		6,880		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		5,335		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 22,517		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Standerfer			$ 93,016
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 93,016

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Operations Group		$ 391,315
Pelman & Dold	audit	18,144
Somerset	403b audit	5,887
Legal adj to Zero		10,306
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 425,652

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 100,246
Unemployment Compensation Insurance	43,307
FICA Taxes	263,348
Employee Health Insurance	307,708
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
	0
Other Benefits	18,040
Central Office Allocation	
TOTAL (agree to Schedule V, line 22, col.8)	$ 732,649

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	3,742
Health Care Worker Background Check	
(Indicate # of checks performed)	3,540
Patient Background Checks	
	11,088
Dues & Subscriptions	10,288
License & Fees	2,384
Central Office Allocation	
Less: Public Relations Expense	(11,088)
Non-allowable advertising	(0)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,954

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	13,968
	594
Seminar Expense	1,916
Central Office	(14,479)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

**See instructions.

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/10 Ending: 6/30/11

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Health Care Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **88,695**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **5,122**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Sulaski & Webb**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees